PUBLIC PROTECTION CABINET
Department of Insurance
Division of Health, Life Insurance and Managed Care
(As Amended at ARRS, September 14, 2021)

806 KAR 17:370. Standardized health claim attachments.

RELATES TO: KRS 304.17A-005, 304.17A-607, 304.17A-700-304.17A-730, 304.17C-010, 304.17C-090, 304.39-010-304.39-340, [~~2008 Acts ch. 127, Part XII, secs 18-20~~], 42 C.F.R. 411.32, 441.203, 441.206, 441.207, 441.208, 441.250, 441.255, 441.256, 441.258

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-720(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the commissioner [~~executive director~~] to promulgate reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.17A-720(1) requires the department to promulgate administrative regulations prescribing standardized health claim attachments to be used by insurers.[~~EO 2008-507, effective June 16, 2008, established the Department of Insurance and the Commissioner of Insurance as head of the department.~~] This administrative regulation establishes requirements for standardized health claim attachments and minimum requirements for routinely requested medical information health claim attachments.

Section 1. Definitions. (1) "Clean claim" is defined by [~~in~~] KRS 304.17A-700(3).

(2) "Health benefit plan" is defined by [~~in~~] KRS 304.17A-005(22).

(3) "Health care provider" or "provider" is defined by [~~in~~] KRS 304.17A-700(9)[~~, as amended by 2008 Ky Acts ch. 127, Part XII, sec. 18~~].

(4)"Health claim attachments" is defined by [~~in~~] KRS 304.17A-700(10).

(5) "Insurer" is defined by [~~in~~] KRS 304.17A-005(29) [~~304.17A-005(27)~~].

(6) "Limited health services benefit plan" is defined by KRS 304.17C-010(5).

(7) "Practitioner" means an individual licensed or certified to provide a health care service in Kentucky.

(8) "Reparation obligor" is defined by [~~in~~] KRS 304.39-020(13).

Section 2. Standardized Health Claim Attachments. If another payment source is identified by a provider, an insurer shall require the provider to include the following health claim attachments, as applicable, for a claim to qualify as a clean claim:

(1) An explanation of benefits statement or noncoverage notice from another payer;

(2) An electronic or paper-based Medicare remittance notice if the claim involved Medicare as a payer; and

(3) A record of all payments by a reparations obligor pursuant to KRS 304.39-010 to 304.39-340.

Section 3. Routinely-requested Health Claim Attachments. An insurer offering a health benefit plan or a limited health service benefit plan for dental only, may routinely request the following health claim attachments in accordance with KRS 304.17A-706(2), as applicable:

(1) A certification of medical necessity;

(2) A complete medical record, or part of a medical record, including:

(a) Discharge summary:

1. Patient identification, including name, age, gender, and medical record number;

2. Name of attending practitioner;
3. Dates of admission and discharge;
4. Final diagnosis;
5. Reason for the admission or visit;
6. Medical history;
7. Significant findings during length of stay or visit;
8. Procedures and treatments;
9. Patient condition at discharge;
10. Discharge medications; and
11. Discharge instructions;
(b) Emergency department report:
1. Patient identification, including name, age, gender, and medical record number;
2. Date of service;
3. Attending practitioner;
4. Chief complaint and symptoms;
5. History of present illness and physical exam;
6. Diagnostic test findings;
7. Clinical impression and diagnosis;
8. Treatment plan;
9. Discharge instructions; and
10. Practitioner orders;
(c) History and physical:
1. Patient identification, including name, age, gender, and medical record number;
2. Chief complaint;
3. Details of present illness;
4. Relevant past, social and family histories;
5. Inventory by body system;
6. Summary of psychological needs;
7. Report of relevant physical exam;
8. Statement relating to the conclusions or impressions drawn from the admission history and physical;
9. Statement relating to the course of action planned for this episode of care; and
10. Name of practitioner performing history and physical;
(d) Nurse's notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Vital signs with graphics, if available;
3. Intake and output record, if applicable;
4. Medication administration records;
5. Date of nurse's notes;
6. Nurse assessment;
7. Nursing intervention;
8. Observation; and
9. Name of nurse;
(e) Operative report:
1. Patient identification, including name, age, gender, and medical record number;
2. Date of procedure;
3. ***Name of*** operating practitioner;
4. Pre- and post-operative diagnoses;

5. List of procedures performed;
6. Operative description including indications and findings;
7. Anesthesia used; and
8. Specimens collected;
(f) Progress notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Discharge or treatment plan;
3. Practitioner orders;
4. Practitioner notes;
5. Attending practitioner name;
6. Results of tests and treatments;
7. Dates of notes; and
8. Chief complaint;
(g) Test results:
1. Patient identification, including name, age, gender, and medical record number;
2. Test findings, including date ordered and date ***completed[~~competed~~]***; and
3. Ordering practitioner name;
(h) Practitioner orders or treatment plan, as applicable:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner orders;
3. Ordering practitioner name; and
4. Order dates;
(i) Practitioner notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner name;
3. Practitioner notes; and
4. Dates of notes;
(j) Consult notes and reports:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner name;
3. Findings and recommendations including notes and reports; and
4. Dates of notes and reports;
(k) Anesthesia record:
1. Patient identification, including name, age, gender, and medical record number;
2. Administering practitioner name;
3. Start and stop anesthesia times;
4. Route of administration;
5. Dates;
6. Notes;
7. Patient vital signs; and
8. Drug administered;
(l) Therapy notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner name;
3. Practitioner orders;
4. Treatment plan;
5. Number of treatments and dates;
6. Therapist's notes; and

7. Dates of notes;
(m) Office notes:
1. Patient identification, including name, age, gender, and medical record number;
2. Practitioner name;
3. Any notes generated for dates of service; and
4. Dates of notes;
(n) Dental records; and
(o) Pharmacy records;
(3) Certification and documentation as identified in 42 C.F.R. 441.203, 441.206, 441.207, 441.208, 441.250, 441.255, 441.256, and 441.258;
(4) Itemized bill; and
(5) Evidence of Medicare secondary payment pursuant to 42 C.F.R. 411.32.

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